

Invited Commentary

Anatomy and Physiology of Primary Care Teams

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Health care teams have a structure (anatomy) and culture (physiology). Team structure has 2 facets: (1) who is on the team and (2) how stable is the team. Primary care teams are often



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composed of a core team or *teamlet* (clinicians working with medical assistants) and an extended-care team (registered nurses, pharmacists, social workers, and behaviorists) that supports several core teams. Team stability means that members of the team always work together and patients on the team's panel receive all care from their team.

Team culture also has 2 components: (1) how team members work together and (2) how teams share the care, ie, distribute patient care functions among team members. How team members work together can be assessed with such instruments as the Primary Care Team Dynamics Survey¹ or the Team Culture Scale.² Examples of sharing the care include training medical assistants to independently identify and close care gaps (overdue cancer screenings, immunizations, or routine diabetes services) and empowering RNs and pharmacists to independently care for patients with uncomplicated diabetes or hypertension, including titrating medication doses within standing orders.³ Sharing the care can make team members' jobs more interesting while reducing clinicians' work that does not require their level of education.

The Meyers et al¹ article in this issue is a study of 18 Academic Innovations Collaborative (AIC) practices that have experienced a 4-year journey toward team-based care. Patients with 2 or more chronic conditions in AIC practices had significantly lower hospitalizations and emergency department visits than those in comparison practices.¹

Primary care teams vary widely in the stability of their team structure and their adoption of a collaborative and share-the-care team culture. How do the 18 AIC practices studied by Meyers et al¹ fare? From surveys referenced in Meyers et al,¹ we know that AIC team members only slightly agreed (3.58 on a 5-point Likert scale) that their teams were stable. Statements about a positive team culture were scored by the practices' clinicians between 3 (neither agree nor disagree) and 4 (agree) on the Likert scale. The share-the-care component of team culture at AIC practices is unstudied. Challenges to team-based care abound: lack of reimbursement for registered nurses and other team members, scope of work laws, clinicians lacking trust in the team, and forging a culture change from "me" to "we."

The article by Meyers et al¹ adds to previous evidence on primary care team effectiveness. Intermountain Healthcare has a long history of team building, dividing its practices into planning, adoption, and routinized phases of team building. Routinized practices have at least 6 years of team-based care with standardized workflows. Patients treated in routinized practices, compared with those in nonteam practices, have higher rates of diabetes control (blood pressure lower than

140/90 mm Hg, hemoglobin A_{1c} lower than 8% [to convert to proportion of total hemoglobin, multiply by 0.01], and low-density lipoprotein cholesterol lower than 100 mg/dL [to convert to millimoles per liter, multiply by 0.0259]), and lower hospital admission and emergency department use.⁴

A 2012 survey of 231 clinicians and 280 staff at 16 primary care clinics in San Francisco looked at core team structure and burnout. Core teams were described in 3 categories: clinicians almost always working with the same medical assistant (*teamlet*), clinicians working with a small group of medical assistants, and no stable core team at all. Team culture was measured with an 8-item Team Culture Scale. For clinicians, the emotional exhaustion component of burnout was high when team culture was low. When team culture was high, emotional exhaustion was significantly lower for clinicians working with the same medical assistant compared with clinicians without a stable team.²

To examine the share-the-care aspect of team culture, a 2013 survey was administered to 326 clinicians and 142 staff in 19 San Francisco primary care clinics. Share-the-care was measured by asking whether clinicians had confidence that medical assistants (MAs) could independently assume responsibility for panel management, ie, identify care gaps, discuss the gaps with patients, and use standing orders to close the gaps for cancer screenings, immunizations, and routine diabetes services. Higher scores on this panel management questionnaire were associated with lower cynicism on the Maslach Burnout Inventory.⁵

The survival of primary care depends on sharing the care. Primary care panels are too large and cannot be reduced because of the clinician shortage. Moreover, in an observational study, 27% of a physician's day was spent on face time with patients while 49% went to electronic medical record documentation and desk work.⁶ The excess quantity of work creates the emotional exhaustion component of burnout while the frustrating quality of work is responsible for the cynicism component. Only by creating teams that share the care, with well-trained and empowered team members taking on functions that do not require a medical degree, can primary care flourish.

The 2016 report High-Functioning Primary Care Residency Clinics⁷ found that building teams in academic teaching practices is far more challenging than in nonteaching practices. The very-part-time faculty and residents have commitments to in-patient and specialty rotations (residents) and teaching and research obligations (faculty) that trump their obligations to the primary care clinic. With clinicians rarely present, teams become large and unwieldy. Creating stable teams, the same people taking care of the same panel of patients, can be a scheduling nightmare. When faculty and residents feel limited commitment to a primary care practice, building a collaborative team culture, difficult enough given the hierarchical culture of medical education, is particularly tough.

One residency practice, the University of Colorado's A.F. Williams Family Medicine Center, has built a core team model that shares the care, with initial impressive results. The essence of the model is the training, at a university-run MA academy, of MAs with greatly expanded roles. With 2.5 MAs per clinician, MAs initiate the patient visit by taking the medical history, identifying any pending orders to close care gaps, and doing medication reconciliation. They are present in the entire visit, performing in-room electronic medical record documentation including pending orders called out by the clinician. After the clinician leaves to see another patient, the MA executes the clinician's orders (laboratory draws, immunizations, and referrals) and reviews the care plan with the patient. Clinicians can often close their electronic medical record within minutes.

Early outcomes demonstrate improved patient access, increased visit volumes that pay for the additional staffing, higher colon and breast cancer screening rates, better diabetes and hypertension control, clinician burnout dropping from 56% to 28%, less time logging into the electronic medical record after hours, and improved patient experience.⁸ Medical assistants appreciate the model because participating in the patient visit rather than being locked out of the visit makes their job more interesting and patient centered.

Evidence is accumulating that primary care teams can improve care, reduce health care costs, and make inroads in the vexing problem of clinician burnout. But not any team will do. To be effective, teams must be stable, build a positive team culture, and share the care. Team-based primary care is a good thing and better teams are an even better thing.

ARTICLE INFORMATION

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